THE RISE AND DECLINE OF THE JEWISH QUOTA IN MEDICAL SCHOOL ADMISSIONS*

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> Yet the question of discrimination against Jews in medicine is the most delicate and difficult chapter in the whole history of prejudice in America. There is less frankness here, more cross currents and division of opinion, greater danger that an intrusion of comment may bring down the wrath alike of those who discriminate and those discriminated against. . . .
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> It would be going too far to ascribe belligerent hatred to the medical colleges. They are honestly disturbed by what they consider menacing conditions. They greatly desire a solution they can believe in, and which will not outrage their sense of justice.
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> Heywood Broun and George Britt, 1931[1]

DURING THE SECOND QUARTER of this century, American medical schools were a little sung battleground in the nation's struggle for civil rights. There was on one side a wide perception that the country had too many Jewish medical students and that the "racial imbalance" should be corrected. The Jewish community, on the other, saw this as anti-Semitic discrimination and vigorously fought newly-created restrictions against admission of Jewish applicants. The confrontation left a lasting mark on American life. It established a legal framework to open society up to future generations of all stripes. New public institutions for professional and graduate education were brought into being. Schools had to re-examine some of their own preconceptions such as what, in fact, are the desirable attributes of a physician, and how does one predict these? In the process, they availed themselves of a wealth of previously excluded talent that helped to shape the biomedical revolution of midcentury and made American medicine the envy of the world. This essay examines some of the forces at play. Old-fashioned anti-Semitism was one piece of the

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problem, but economic interests and social conceits constituted its major dimension.

Before 1920 little restriction was placed on Jews in American professional schools. The colleges had originally been founded, by and large, by Protestant churches. They were meant to produce an educated ministry and to train missionaries. Complacency of the established universities and the academic mediocrity it had engendered led to major reforms of higher education by the turn of the 20th century. Long after the schools had taken on a broader secular purpose, admissions were based largely on social class. They were further to be challenged by gifted and ambitious newcomers from eastern Europe. The sons of the immigrants were charged with unpleasant manners and clannishness. The real threat was that they wanted desperately to enter the mainstream.

The Jewish Passion for Medicine

Jews sought to become physicians in far greater proportion than did other segments of the American population after 1880. In 10 major cities surveyed over five-year periods, the number of Jewish physicians graduated had increased from seven in 1875–1880 to 2,313 in 1931–1935.[2] The secretary of the Association of American Medical Colleges in 1934 found that more than 60% of the 33,000 applications on file were from Jews.[3] The explanation must be sought in an almost mystical reverence for medicine that went back more than a thousand years and had deep religious, cultural, and socioeconomic roots.

Jewish immigrants to America during the second half of the 19th century, both those from the earlier German (1860–1880) and from the much larger eastern European waves (1880–1920), brought with them the highest esteem for medicine. The heirs of the German immigrants were quite Americanized by 1900, and largely shared an aristocratic contempt for the backward eastern European Jews. Other careers had been generally closed to the latter by law and custom. A large proportion of all Russian medical students was Jewish. They sought the education for social advantages in addition to the calling's traditional prestige. A medical degree made it possible for one to leave the Pale and enter a city. It also afforded mobility at a time when Jewish communities were ever at risk of being uprooted.

Coming to America, undreamed of opportunities soon seemed within grasp if only one worked hard enough and acquired an education. Families underwent great privation to educate their sons. During the same period, a wave of xenophobia overtook the country. The Immigration Acts of 1921 were

predicated on a presumed inferiority of eastern and southern Europeans vis-à-vis those from northwestern Europe. Akin to this was a widespread and authentic apprehension about alien and revolutionary ideologies. Antagonism to foreigners reached deeply into proper strata of American society. It permeated universities and, ultimately, medical education.

Restriction in Medical School Admissions

Frightful deficiencies of American medicine were unroofed by the Civil War of 1861–1865. Their recognition triggered a fundamental restructuring of medical education, licensure, and hospital practice during the next half century. Before 1910 there had been few requirements for admission to medical school. There were approximately 200 of the latter, mostly proprietary or cultist. Most schools were private ventures, money-making in spirit and object. Courses were short, faculty often untrained in the medical science of the day, and students often were graduated without ever having touched a patient. This faulty educational system had important economic consequences for physicians as well as for patient care. The surfeit of practitioners often resulted in low incomes. At times, physicians had to supplement their incomes with nonmedical vocations. Competition among young graduates to get started led some into contract practices frowned on by the profession. Contract medicine was an accepted feature of practice throughout Europe at the time. Here, however, as a *Journal of the American Medical Association* editorial put it in 1906, contract medicine represented "one of the most serious evils threatening the medical profession of this country." Health maintenance organizations and prepaid insurance first became "ethical" two generations later.

The tightening of standards for medical education reduced the number of schools from 162 in 1906 and 137 in 1910 to 83 in 1921 and 76 in 1931. More than 90% were now in Grade A. Another burst of retrenchment occurred in 1933 at the recommendation of the American Medical Association in response to the declining incomes of physicians during the Great Depression.[4] Cutbacks on prospective physicians fell disproportionately on children of immigrants in roughly the order of recency of their arrival. Development of quotas was instrumental in accomplishing this.

Acceptance practices of the medical schools took into account a variety of the candidate's assets. Scholastic aptitude was only one of these. Although it was acknowledged to be the most important variable, premedical academic performance might be discounted because it could be a measure of culturally-driven "book learning" rather than of authentic intellectual or professional

capability. The standing of preparatory colleges and geographic factors were important. Interviews carried great weight. Nominally, they were meant to evaluate character, personality traits, and emotional stability. These subjective judgments often appeared quite differently to interviewer and interviewee.

The attitude of much of the medical profession on this subject during the 1930s was illustrated in a systematic survey of the health care system conducted by the American Foundation.[5] Views on possible reforms were solicited from physicians who had been in practice 20 years or more. Among the approximately 2,100 respondents, there was a consensus that important motivating factors for the choice of medicine as a career included the appeal of a dignified profession, for some the lure of science, of social service and opportunities for big fees. Reservations about admission of children of immigrants were widely expressed. Many were intelligent and competent, but they tended rather more than those of older American stock to regard the medical profession as a money-making business. Their ethical viewpoints, thus, were lower than expected of a physician.

Documentation of discrimination was difficult. The subject was touchy, and academic institutions usually denied that it existed. Statistical analyses of the percentages of applicants admitted, adjusted for various objective measures, e.g., grades and extracurricular activities, were therefore called on as the principal tool to substantiate the charges. A variety of indirect methods were employed to establish the Jewishness of candidates in the first place. Jewish names, particularly when connected with residence in areas heavily populated by Jews, were a first handle. Available statistics are limited and, in retrospect, of varying reliability. Early data presented by Jewish agencies were supplied by school authorities. The latter became fed up by the mid-1930s and many refused to cooperate in later surveys. Numbers were then estimated by necessarily less accurate methods: names, follow-up of house staff appointments, and, sometimes, personal interviews. Figures generated in this way were systematically lower than those provided by the schools. Nevertheless the trends in both were quite concordant. In what follows, I point out several errors in published data as well as those that seem more trustworthy.

A special investigating committee of the New York City Council summarized discriminatory features on the applications for admission to professional schools in 1946 this way:[6]

> Prior to 1920, an applicant for admission to a professional school was required merely to set forth in the application prepared by the school the following information: Name, address, age, place of birth, name of college, years in college, scholastic record and recommendations.

Subsequent thereto, the information required of the applicant included a statement concerning his "religion" and "place of birth of father and mother." Thereafter was added the requirement that he furnish a photograph.

Some of the schools, apparently because of criticism concerning the requirement that the applicant state his religion, substituted a question concerning the "racial origin" of the applicant. Thereafter, this question was dropped and applicants were required to state their "mother's maiden name."

To this list might be added "change of name." By 1957 only 21% of medical school application forms requested information about church affiliations or religion. Thereafter, such questions were eliminated from the standardized forms developed by the Association of American Medical Colleges. Reliable data on the number of students by religion were generated for the first time in 1978 by the Association, based on voluntary statements by those taking the revised Medical College Application Tests rather than the application proper.

Quota systems had several expressions. Some were geographic and derived from the charters of state schools dedicated to residents. Sectarian medical schools had their own constituencies. Prestigious private institutions viewed themselves as producers of the nation's future leaders and wanted their student bodies to represent a diversified, broad population. Ivy League schools led the way. At Columbia University, President Nicholas Murray Butler devised a policy of "selective admissions" explicitly to limit enrollment of the burgeoning Jewish population of New York City in favor of an elite "natural constituency" in 1918.[7] The medical college was the first professional school to adopt this policy.[8] One analysis[9] cited a decline of Jewish admissions to the College of Physicians and Surgeons from 14 to fewer than 4% between 1920 and 1948. These numbers are at variance with those provided by the university[8] and others,[6] but the relative decline in Jewish admissions was no less precipitous in all.

In 1922 President A. Lawrence Lowell suggested a less subtle *numerus clausus* for Jewish applicants to Harvard College, a proposal that caused much dissension in the faculty.[10] A fixed number was not established for the Harvard Medical School as it had been for Harvard College, but friendly historians acknowledged that anti-Semitism was a significant factor in the low "incidence" of Jewish students there from 1910 to 1935.[11] At Yale Medical School a strict quota system came into being with the support of Milton C. Winternitz, the dean from 1920 to 1935. Winternitz was almost a caricature of an American Jew striving to become part of gentile society.[12] A brilliant pathologist, he had been advised in his earlier years by William

Henry Welch that he was unlikely to inherit the mantle at the Johns Hopkins University and to look elsewhere. Winternitz raised the Yale school from an inferior status to become one of the finest in the country. He placed stringent restrictions not only on students, but also on appointing Jewish faculty and house staff.[13]

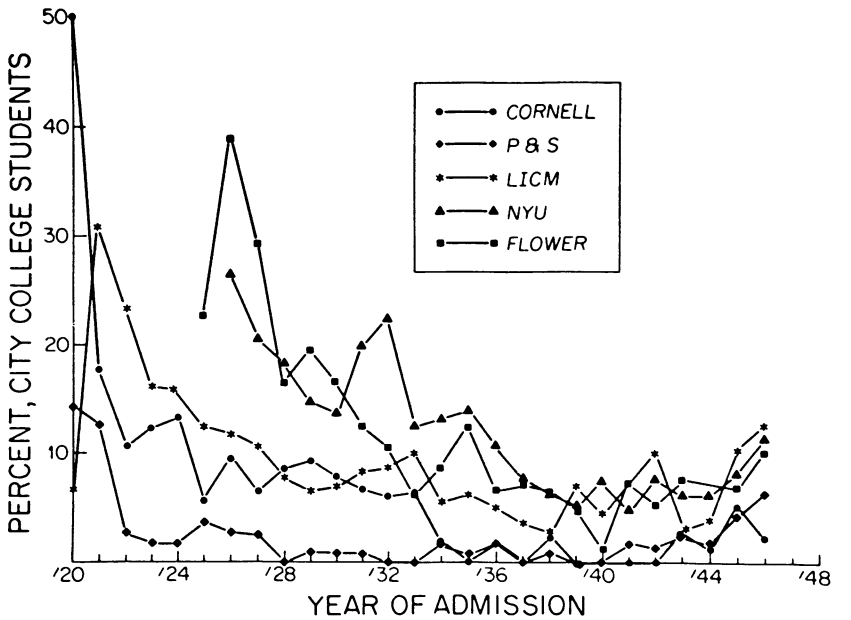
In 1934 the dean of Cornell University Medical College, W. S. Ladd, wrote that "All students are considered on the same basis and there is no specific limitation of Jews."[14] But another letter, signed by him on April 25, 1940, stated: "We limit the number of Jews admitted to each class to roughly the proportion of Jews in the population of this state."[6] Analogous conditions obtained throughout the country with much variation from institution to institution.[1,15–17] Quotas did not always go down well in the academic community. Dean Isaac H. Manning of the University of North Carolina Medical School was forced to resign by President Frank P. Graham in 1933 because the quota was "not in conformity with the general policy of the university." Nonetheless the practice went on there as before in following years.[16]

Two Jewish organizations separately estimated the number of Jews admitted to medical schools nationwide from 1932 to 1936[2,17] based on the different methods already indicated. There was considerable disparity in the absolute numbers, but each reported a large and comparable decrease over the course of the four years. They did not, however, take into account that the total number of medical students fell progressively during the same period. Calculated on a percentage basis, there was no selective diminution of Jewish admissions until 1936. Morris S. Lazaron, a leading anti-Zionist rabbi, did not believe that anti-Semitism was an issue.[15] He reported that Jewish graduates had increased from 12.2% in 1924 to 21.7 in 1933. The latter figure was, however, inflated by outdated information from the New York Homeopathic Medical College that, until 1930, had the highest proportion of Jewish students in the country. In 1931 admissions of Jews dropped sharply. The best guess is that approximately 17% of medical students in America during that era were Jewish.

An analysis by A. L. Shapiro[9] reported a drop in Jewish enrollees at New York University and the Long Island College of Medicine from 30–40% to less than 20 between 1920 and 1940. These figures were in error. Jewish medical students constituted at least one half of the total at New York University during that period. The liberal policies there were largely the work of Dean John Wyckoff, a man of great probity, much admired as clinician and educator. He found that premedical students trained at the City College of New York performed better academically at New York University School

of Medicine than did those from other colleges.[18] This did not prevent the proportion of City College candidates admitted from falling sharply during the 1930s (Figure); Jewish applicants were admitted instead from premedical programs at New York University or elsewhere. In face of the statistics, the administration of the City Colleges literally discouraged prospective candidates from applying to medical school. When the premedical students could afford it, they transferred to other colleges.

The closest expression of the Association of American Medical College's views appeared in a survey of medical schools at mid-century that it cosponsored with the Council on Medical Education of the American Medical Association. The report stated that there had been racial and religious discrimination by medical schools in the past and it was now without legitimate defense.[19] The prevalence of such discrimination, however, had been exaggerated, and the motives and procedures of admission committees were often misunderstood or distorted. The authors were concerned that some methods used to eliminate discriminatory practices might limit freedom to select students who would advance the quality of medical education. Careful selection by going beyond paper records and college grades might be handi-



Decline in admission of City college graduates to five New York City medical schools, 1920–1946. Abbreviations: Flower, New York Homeopathic Medical College, LICM, Long Island College of Medicine; NYU, New York University College of Medicine, P&S, Columbia University College of Physicians and Surgeons.

capped by pressures to limit the personal information requested of an applicant. This could legitimately include questions about the applicant's sex, race, nationality, and preference in religion.

The Jewish medical community responded by creating a distinguished Medical Committee for Research of the Conference on Jewish Relations in the mid 1930s. It was chaired by Dr. Jacob A. Goldberg,[2] and put out the previously cited numbers on the decline of Jewish medical students. It also found that in 1939 47% of Jewish physicians practiced in New York State, 9% in Illinois, 7% in New Jersey and Pennsylvania. The influx of refugee physicians from Europe was just beginning. They congregated in the same areas and added to pressures to limit production of new medical doctors.

The horrors of Nazism did not spare physicians. Twenty-eight hundred of the 3,500 Jewish physicians in Poland were killed in the Holocaust. From 1933 to 1945 some 6,000 European physicians escaped and found their way to the United States.[20] Their plight aroused much indignation among Jews and Gentiles. Despite these humane impulses and the relative decline in the number of physicians in the United States generally, other forces had a countervailing effect. Systematic efforts were made by medical societies to exclude the emigres from becoming licensed. The real basis for rejecting them was economic. The depression had already cut into the incomes of American physicians. Denied access elsewhere, 65% of 1,802 refugee practitioners were concentrated in New York City in 1941 and added to the competitive burden.

Jewish Students Go Abroad

Restrictive admission policies caused much bitterness among students facing rejection. Many turned to dentistry, optometry, podiatry, or pharmacy as an alternative. Occasionally it was possible to acquire legal residence in another state and so to become eligible for a state university. Twenty-eight tax-supported and three private schools drew at least 90% of their students from within their own borders. A very few applicants were in position to reap the reward of family beneficences to universities—an unwritten but long accepted practice among America's privileged classes. It was widely rumored that one could bribe one's way into medical school. There are reasons to believe that the ways were greased on occasion—precise numbers are not known. The vast majority of applicants were too scrupulous or lacked the financial resources or political connections to try this route.

A more acceptable option was to go abroad for a medical education. This practice began in the 1920s, peaked in 1932 or so, and virtually ended at the onset of the Second World War. The number of students in European schools

in 1932–33 was 2,052:[21] more than 90% of Americans studying in Europe at the time were Jewish.

Accessibility of European schools was based on a different premise of their academic missions from that of their American counterparts. For centuries, qualified students were admitted from various parts of the world without restriction and then returned to pursue their careers where they wanted. It was thus in a school's economic and academic interest to attract foreigners. By contrast, students in America predominantly practiced in their place of origin, and their numbers were limited to meet the needs of the country. In fact, numbers declined during the 1930s despite a great increase in the population.

Most of the Americans went to Scotland, Switzerland, and, for a time, Germany. Scottish schools had advantages beyond their historical religious tolerance: they did not require learning a new language. They were relatively inexpensive. The academic quality was high. The schools fell into two categories: university and extramural. At first, Americans attended the Universities of Glasgow, Edinburgh, or St. Andrews. The capacity of these schools was saturated by 1931. Preference was now given to foreigners who came from parts of the British Empire that had no medical schools of their own. The bulk of the American students thereafter attended the extramural schools, those attached to hospitals rather than universities. The strengths of the hospital-based schools were in clinical medicine rather than theoretical or basic sciences. There were three extramural institutions in Scotland: St. Mungo's College Medical School and Anderson's College of Medicine in Glasgow, and the Medical School of the Royal Colleges of Edinburgh. The Triple Qualifying Examination permitted award of a "Licentiate" and had been accepted for many years by the National Board of Medical Examiners in the United States.[21]

Faced with the entrance of large numbers of refugee physicians and of Americans who had bypassed the restrictive educational system here, the medical community favored limiting licensing of those with foreign education. The screws were applied first in New York State, one of the country's most liberal, in October 1936. The Board of Regents modified its previous policy of endorsement, i.e., awarding a license upon presentation of verifiable proof of education and licensing outside of the state, to require an examination. Even this did not succeed: 85 to 90% of the Scottish graduates passed the New York State license examinations. Further measures were needed.

These were accomplished by Dr. Willard C. Rappleye, dean of Columbia University's College of Physicians and Surgeons. Rappleye was one of the

most respected medical educators and health planners in America during his time. In 1938 the Association of American Medical Colleges sent him to inspect the European schools where Americans were studying. His visit to Scotland was considered cursory and aroused considerable indignation in those institutions. He apparently, however, enjoyed the support of the General Medical Council of Great Britain in this effort.[22] On his recommendation, the State Education Department decided in January 1939 that it would no longer issue certificates of qualification to new applicants from the extramural schools in Britain. Other states followed in short order. Then came constraints on house-staff training of foreign graduates and exclusion from the National Board examinations. Reciprocity—acceptance of one state's licensing by another—was increasingly done away with to limit movement of New York physicians to other areas. This accelerated the decline in the number of graduates sitting for state board and increased those taking National Board examinations. By this time the issue had become moot for most Americans abroad. The Second World War was under way and the State Department forbade travel to Great Britain. Americans with advanced standing in the Scottish schools had to seek an alternative. Some resumed their studies in Switzerland, a nonbelligerent country. More had to start all over again in this country, usually in unapproved institutions. Some dropped out altogether. Most graduates of the foreign schools became certified specialists. Of 59 Americans in the class of 1941 from Lausanne, only 26 went into general practice. Some rejected here achieved stature in academic as well as clinical medicine.

Unapproved Medical Schools

A proportion of the frustrated premedical students beat the system by attending unapproved medical schools and taking a chance on becoming licensed to practice. There were two such institutions: the Middlesex University School of Medicine in Massachusetts and the Chicago Medical School. Each had beginnings in schools that preceded the Flexner report and later became defunct. During the 1930s and 1940s, vigorous efforts were made to breathe new life into them with the aid of Jewish supporters.

Middlesex was formed originally in 1848 and reopened in 1914 as the Middlesex College of Medicine and Surgery. Between 1915 and 1939 it had graduated 918 students. It was a proprietary institution headed by John Hall Smith, a Mayflower descendant and wealthy Boston Protestant surgeon. He was a driven entrepreneur and sought to create his own university and medical school. Toward this end, he purchased a beautiful 90 acre tract of land in

Waltham, designed, and built a new facility there in 1926. The physical plant was excellent. From the outset, the American Medical Association's Council on Medical Education placed Middlesex into the grade C ("totally unacceptable") category. For the next 30 years it fought attempts by Middlesex to improve itself and acquire recognition.

Clinical resources were woefully deficient. A few municipal hospitals in Massachusetts opened their wards to Middlesex students, but efforts to broaden its teaching base were blocked by hospital and state authorities. Graduates were not permitted to take the National Board examinations but could seek licensure in Massachusetts. Students had to fend for themselves in Boston or other facilities willing to take them. Despite the difficulties, hundreds passed the examinations, became fellows of the Massachusetts Medical Society, and many served as commissioned officers in the armed forces. To some, at least, their educational travails left an abiding sense of humiliation and anger.

Because Middlesex graduates could practice only in Massachusetts, the number of physicians in the state increased out of proportion to the population.[23] In response to protests that Massachusetts was becoming a dumping ground for medical graduates, a State Approving Authority was created in 1936 to evaluate—and ultimately to kill—Middlesex.[24] Many administrative and academic attempts were made to accommodate the Authority. To meet requirements that the faculty be enlarged, many senior refugee scholars from Europe were recruited. Endeavors to create a financial base for the institution came to nought, largely because no substantial endowment could be generated so long as the school was not approved—a Catch 22 situation. A pivotal asset of Middlesex was its charter to award doctoral degrees. Its Achilles heel was lack of sufficient teaching hospital facilities.

The Department of the Army wavered in its policy of accepting Middlesex graduates. The exigencies of the war reduced house staff personnel everywhere, and out-of-state hospitals became more permissive toward awarding clinical clerkships. This provided an opportunity for recent graduates to take examinations in states other than Massachusetts. Approximately 200 were ultimately registered in New York.[25] In 1944 the Approving Authority denied future graduates the right of examination by the Board of Registration in Medicine.

Increasing anger at discrimination as well as the tragedy unfolding in Europe resurrected old ideas of creating a Jewish-sponsored university in America.[26,27] Several groups came into being toward this end. The first objective was to acquire a campus. One committee, led by Rabbi Israel

Goldstein, was based in New York. Smith negotiated with the New York committee in 1946 to pool resources: Middlesex would offer its campus and existing facilities, and the committee would assume responsibility for the survival and ongoing support of the medical and veterinary schools. The condition was added that there would never be discrimination on the basis of creed or ethnic origin. Thus was Brandeis University born.[27,28]

Some expressed discomfort that the image of the new university might be compromised by its association with Middlesex. Rabbi Goldstein acknowledged that "I was not in a position to pass judgment on the question whether the opposition to Middlesex was due to its lack of adequate funds and facilities to develop an approved medical school, or, as Mr. Smith contended, was due to religious bias owing to the fact that it was a non-quota school, or a combination of factors."[27] He soon obtained the support of Albert Einstein, and the committee was expanded and reorganized as the Einstein Foundation for Higher Learning. It was another matter to revive the medical school while trying to obtain funds for the new university. Although the Medical Society had been thwarted in having the charter revoked, everyone involved soon recognized that the medical school was a dead issue. The official announcement came at the 1947 commencement exercises when the last few senior students were awarded their degrees.

While no statement ever was made to the effect, many of the trustees and faculty of Brandeis assumed that the establishment of a medical school would be a major aspect of the university's ultimate development.[27] The first president, Abram L. Sachar, recounted acrimonious political infighting among the founders.[28] Einstein soon dissociated himself from the enterprise. Ten years later strong departments of biochemistry and biomedical research developed there.

The Chicago Medical School had a happier outcome. Now the University of the Health Sciences/Chicago Medical School, it was reconstituted in 1912 from night schools deemed unsatisfactory in the Flexner report. The development into an approved institution was the singular accomplishment of its dean and president from 1932 until 1966, John Jacobi Sheinin. By all accounts, Sheinin was a strong and effective, if autocratic, leader. His was a Horatio Alger story. Born in Russia, he arrived as a boy in 1920, penniless and not knowing English. His speech retained a Yiddish accent throughout his life. Between 1924 and 1932 Sheinin completed undergraduate, M.D., and Ph.D. degrees, and did creditable research in neuroanatomy.

During the early years of his leadership, Chicago Medical School was rated as class B. Its graduates were admitted to the Illinois examinations and were

accepted into the Medical Corps of the Army and Navy during the Second War. Its professed goal was to train practitioners of medicine rather than academicians. The student body became perhaps 80 to 90% Jewish and remained that way until the 1970s. A considerable portion of the freshman class of 1939 comprised "Scotties", Americans who had already spent time at medical schools abroad and were unable to return because of the war. The principal teaching facility was the Cook County Hospital, an immense public institution that opened its wards to several other medical schools as well. The Michael Reese Hospital, founded by German Jewish immigrants of an earlier generation, would have nothing to do with the Chicago Medical School. The Mount Sinai Hospital of Chicago, formed by eastern European Jews in 1914, during Sheinin's tenure became one of the major clinical facilities of the Chicago Medical School and both institutions prospered.

Sheinin succeeded in raising large sums of money from private contributors and corporations.[29] He also attracted capable faculty members. Among these were refugee scholars. A major asset was Israel Davidson, who moved from the University of Illinois in 1947 to head the department of pathology. Davidson was born and educated in Austria. He later became the editor of the *American Journal of Clinical Pathology.* Sheinin did not publicly identify with Jewish causes, and the administration did not relish its Jewish image. At no time did it receive support from Jewish communal organizations. In 1946 Sheinin consulted with the Einstein Foundation about the possibility of obtaining a subsidy for the Chicago Medical School. In return, a number of qualified premedical students from Brandeis University would be admitted to the medical school. The Foundation regretted that it was not in position to extend help at that time.[27] Only in 1948 did Chicago Medical School become fully accredited.

Legislative Remedies

The sense of outrage in the Jewish community led to a series of confrontations with private academic institutions following the Second War. Returning veterans were not in the mood to be denied. The Anti-Defamation League of B'nai B'rith, the American Jewish Committee, and the American Jewish Congress promoted model legislation designed to prevent discrimination in education. In this they had the support of President Truman's Commission on Higher Education and his Commission on Civil Rights: both denounced discriminatory admissions policies and recommended legislation to ensure fairness. They were opposed no less vigorously by Columbia and sister

universities on the grounds that such legislation would compromise academic freedom.[8]

In 1945 Rabbi Stephen S. Wise, a national figure in public affairs, attempted to persuade the New York City Tax Commission to cancel the tax-exempt status of Columbia University because its College of Physicians and Surgeons had discriminated against Jewish students. It thus "betrayed the democratic purposes for which public subsidy for education is granted."[27] A case against the Commission was brought before the State Supreme Court by Attorney General Nathaniel Goldstein. Justice James B. McNally ruled against the complaint because the Attorney General was not an aggrieved individual and therefore not a proper plaintiff. The judgment was sustained on appeal but it stimulated proposals for remedial legislation in New York, New Jersey, Massachusetts, and Pennsylvania.

On September 11, 1946 the Council of the City of New York created a special committee to investigate the difficulty experienced by graduates of the city-maintained secondary schools and colleges in obtaining graduate and professional education.[6] The large majority of the students at City, Brooklyn, and Hunter Colleges at the time were Jewish. The Committee was headed by Councilman Walter R. Hart. It documented a great decrease in the admissions of graduates to the five medical schools located in the city (Figure). It did not point out that of those who were accepted, three fourths were from the small Gentile minority.[1] The medical schools were private institutions but gained two substantial subsidies from the city: exemption from taxation as nonsectarian educational institutions and use of municipal hospitals for clinical teaching. The Hart committee report was accepted unanimously two months later. It recommended that the city take legal steps against discrimination in the medical schools, and that the state should create a university that would have medical and dental school components. Up to that time, 34 other states had their own universities; 19 of these also had two or four year medical schools. New York had none. Its legislative bodies had considered the advisability of establishing state institutions of higher learning as far back as 1784. The decision repeatedly was: no—they might weaken the private colleges.

The New York State legislature created a Temporary Commission on the Need for a State University in late 1947. The proposal created much discomfort in the private medical schools. At this time, Dean Rappleye testified that Columbia's medical students were accepted without regard to race, creed, color, or national origin; and only on the basis of their qualifications and promise to become competent and ethical physicians.[31] Some did not see it that way. A Committee on Higher Education of the New York Chapter of

the American Jewish Committee[32] estimated that it was from two and a half to five times more difficult for a Jew to be admitted to seven of nine medical schools in New York State than for Christian applicants of comparable academic standing. A detailed analysis of the Cornell University Medical College disclosed that 4.9% of Jewish applicants were accepted compared with 15.3% of Catholics and 24.6% of Protestants. These numbers understated the situation. Jewish students from New York, later to be leaders in academic medicine, were told by their premedical advisors not to waste their money in applying to Cornell.

The importance of the medical school squeeze in creating a State University is indicated by the titles of two of the Commission's four staff studies: *Education for the Health Services* and *Inequality of Opportunity in Higher Education.* The report agreed that the statistics on admissions showed inequality of treatment of applicants of equal academic standing from the same geographic location. Governor Thomas E. Dewey, Harry Truman's likely contender for the presidency of the United States, reluctantly endorsed the recommendations of the Commission in February 1948. Some months later the legislature declared that "... the American ideal of opportunity requires that students, otherwise qualified, be admitted to educational institutions without regard to race, color, religion, creed or national origin."[33] An exception was made in deference to Catholic sensibilities: "It is a fundamental American right for members of various religious faiths to establish and maintain educational facilities exclusively or primarily for students of their own religious faith or to effectuate the religious principles in furtherance of which they are maintained." A state university was enacted concurrently.

Discrimination did not end there. To resolve ongoing controversy, the Board of Regents retained Dr. Howard Wilson of the Carnegie Endowment to direct a study of the subject in 1951. Wilson's report[34] concluded that larger proportions of Protestant applicants were admitted to New York's medical schools than Catholics of equal scholastic qualification, and more Catholics than Jews. For Jews accepted, the admission rate was higher if their parents were born here than if they were born abroad. There also were discriminatory patterns among Catholics admitted: Italians fared less well than did non-Italians. Only at New York University were students selected in such a way that at each level of academic achievement were the three religious groupings represented in approximately the same proportions.

The situation for Jewish candidates improved greatly during the 1950s, but they were still at a competitive disadvantage. By this time, Jewish admissions in New York State had increased over those prevailing two decades earlier.

Even so, the bulk of these attended New York University or the Downstate Medical Center. Cornell University Medical College was charged with continuing its quota policy[35] and came under pressure for violation of the Educational Practices Act. The Philadelphia Fellowship Commission made public a five-year survey of premedical students from the University of Pennsylvania and Temple University in April 1957. Its conclusions were much like those of the earlier Wilson report in New York.

The State University of New York rescued and took over three financially strapped, previously private medical schools: Syracuse in 1950; the Long Island College of Medicine in Brooklyn, now the Downstate Medical Center, 1950; and Buffalo in 1962. The Stony Brook Health Sciences Center was the only facility created *de novo* and it was first authorized in 1963. Sensitivities about discriminatory quotas were also an acknowledged factor in starting the University of Connecticut School of Medicine in 1961.

A Jewish Medical School?

Another pathway contemplated for countering the discrimination was to create a Jewish medical school analogous to those already existing for Christian denominations.[1,27] The wisdom of building Jewish schools of secular learning had long been debated. Would they result in an intellectual ghetto? Would they exacerbate anti-Semitic sentiments? There had been two abortive attempts to develop medical schools more sympathetic to Jews in the early 1940s, the Gorgas Institute of Medical Sciences in New York City and the Essex College of Medicine and Surgery in Newark. Both were stopped by the respective state medical societies amidst bitter charges and countercharges.

In the decade that followed World War II, the nation faced up to a shortage of physicians and made efforts to increase the number of medical students. The Albert Einstein College of Medicine of Yeshiva University was chartered in 1951. Planning was begun a year before by Dr. Samuel Belkin, president of the University, and former Attorney General Nathaniel Goldstein. They solicited and won the agreement of the neuropathologist, Harry M. Zimmerman, to direct the organization of the school.[13] The rationale for creating another college of medicine was to alleviate the shortage of health personnel, to insure young men and women with necessary talent the opportunity for medical education, to advance the medical sciences, to carry on a great tradition of the Jew in medicine, and to make a collective Jewish contribution to American life that would earn the gratitude of all humanity.

At the beginning, there were strains between the university and the medical school and between different segments of the Jewish community and the

medical school. Contradictions between Yeshiva's *halachic* (Sacred Law) principles and the requirements of modern medicine—anatomical dissection, autopsies, contraception, abortion, work on the Sabbath—had to be resolved. The Boards of the Federation of Jewish Philanthropies and the two major hospitals it supported—Mount Sinai and Montefiore—were predominantly German-derived. They distrusted the Orthodox leadership of Yeshiva University and did little to aid it. One of the steps taken to increase the base of support was to dissociate the name of the school from that of Yeshiva University. Professor Einstein was approached in Princeton for permission to name it after him.[36] The published account did not fully disclose the tenor of the conversation. Einstein was reluctant to go along with a sectarian institution. After being shown evidence of Cornell's restrictive guidelines, he consented on the understanding that the new school would not be discriminatory. Funds then started coming in at a good pace and a strong faculty was recruited. The medical college rapidly achieved national stature.

Yeshiva University at the beginning was eager to have Montefiore Hospital join with it—even willing to name the institution the Montefiore Medical School. The Board of Trustees of the hospital was not interested at the time. It did look into the possibility of creating its own medical school. Consultations were held with President Sachar about an association with Brandeis University but Montefiore finally affiliated with Einstein in 1963 and became its major clinical resource.

The administration of the school has remained faithful to its commitment to be nondiscriminatory in its admission policies. Two accommodations to the religious nature of the parent university were made: the library is closed on Saturdays rather than Sundays; nonkosher food may not be served at the Weiler Hospital, the private facility of the center. Beyond this, the University has not intruded into the professional conduct of the medical school.

The Bane report, *Physicians for a Growing America*, was published by the U. S. Public Health Service in 1959. It recommended creation of new medical schools to meet the needs of the expanding population, increased demands for medical care devolving from improved socioeconomic conditions, and the entry of sizable numbers of physicians into research activities. This provided an opportunity for starting the Mount Sinai School of Medicine. The idea of developing a medical school at the hospital dated back at least to 1943. There were two separate motivations. Both flowed from the changing character of American society and its effect on the mission of the institution. The hospital had changed from its original purpose of treating indigent Jews to become a large and prestigious clinical and research center. Its major

raison d'etre then was to provide postgraduate training for Jewish physicians in the metropolitan area.[37] Leading members of the staff had been distressed by discrimination against Jews applying to medical schools and this previously constituted one unwritten goal for creating a school.

The other reason was no less compelling: the hospital's prestige was being placed in jeopardy by opportunities opened up for talented Jewish physicians in academic institutions after the war. During the 1950s the dollar volume of its research grants exceeded that of most university medical schools. Now the Hospital had gone as far as it could go. The teaching associations with Columbia's College of Physicians and Surgeons were considered inadequate. The first formal step toward establishing a medical school was taken in December 1958, and it came into being seven years later. The founding figure, later dean, was the pathologist-in-chief, Hans Popper, a refugee from Vienna.

Affiliation with a university would materially enhance the school's prestige and so attract better students, faculty, and external grant support. Early negotiations with Brandeis University seemed promising. There was "a natural community of interests between the two institutions functioning under Jewish sponsorship." The great distance between Waltham and Manhattan was an undesirable but not necessarily prohibitive condition. This affiliation did not materialize because the Brandeis faculty was reluctant to become submerged in a medical school. A suggestion that the new school join with the Einstein college of Yeshiva University was overwhelmingly voted down by the staff. Finally, Mount Sinai joined the City University of New York. In return for expanded teaching and community health services, the arrangement allowed the School to control its own finances and permitted access to other city teaching facilities. The original professors were Jewish but, like the hospital, the school was to be nonsectarian. Minority recruitment programs were instituted from the beginning.

The Federation of Jewish Philanthropies had long been a benefactor of the Hospital. It also was sounded out by the Montefiore Hospital that wanted to create its own medical school. The Federation was not able to bring the two institutions together in 1963—neither would agree to letting the other be the seat of the basic sciences facility. In the end, construction moneys went to Mount Sinai, and Montefiore affiliated with the Einstein College. At present, most of the trustees and benefactors of Mount Sinai and major affiliates—the Beth Israel Medical Center and the Jewish Home and Hospital for the Aged—are Jewish, but many of its chief officers and senior faculty are not.

Concluding Remarks

The preponderance of the evidence is that quotas were a discriminatory and unfair feature of the medical school admissions process before midcentury. It strains credulity to attribute the nigh-total exclusion of Jewish City College graduates to a lack of character, attractive personality traits, or emotional stability. The City Colleges of that era, despite it all, turned out more than their share of Nobelists in medicine and physiology: Arthur Kornberg, Julius Axelrod, Rosalyn Yalow, and Gertrude B. Elion. Hear Kornberg:[38]

> In the grade schools and high schools of Brooklyn, I was enclosed in a circle of Jewish students and friends and was unaware of any anti-Semitism directed at me. This innocence persisted until my senior year at the academically prestigious City College of New York, whose student body was then 90 percent or more Jewish. Then came the disappointment of being rejected by virtually all of the many medical schools to which I applied. But it came as no surprise. I resented then that at the College of Physicians and Surgeons of Columbia University, a close neighbor of City College, an endowed scholarship for a City College graduate went begging for nine years because there were no candidates. To this day it rankles me.

Axelrod and Benacerraf also bore witness to the phenomenon. The analysis presented here suggests that the discrimination was only in part an expression of xenophobia and anti-Semitism. It was fueled by competitive economic pressures of the practitioners of medicine. Limiting medical school enrollments toward this end must be counted among other sources of public dissatisfaction that broke the monolithic power of organized medicine after 1945. The ethnic prejudices of the earlier era are now less onerous. The political militancy of the Jewish community, the public revulsion against the logic of Nazism, and the explosion of biomedical science with its need for qualified personnel changed this pattern in the wake of the Second War. Admissions practices are now quite open. Social policy considerations enter into preferential admissions for minority candidates or those dedicated to a needed category of practice, e.g., military, rural, or family medicine as distinct from a specialty. Major Jewish organizations oppose reimposition of racial quotas for medical school admissions in the name of affirmative action. The Anti-Defamation League joined other *amici curiae* in the Bakke case of 1977. It contended that the University of California, in denying admission to a well-qualified white Jewish applicant in favor of a non-white candidate with lesser credentials solely on the basis of his race, violated the Equal Protection Clause of the Constitution. The Supreme Court concurred. The end is not yet. Disagreements about the predictive validity of aptitude tests go on unabated.

Some insist that they contain cultural biases and are unfair; others counter that such claims camouflage value judgments by rhetoric and statistical legerdemain.

It is ironic that the proportion of Jewish medical students now is substantially smaller than that prevailing in the heydey of restrictive quotas. The percentage entering medical school in 1988 identifying themselves as Jewish was 8.6[39] while that in 1935 was somewhere about 12.0–14.1. The decline holds true when adjusted for changes in the size of the population and the student pool. The academic performance of Jewish medical students, as gauged by election to the honorary society, Alpha Omega Alpha, does not differ from that of Gentile students.[40] The decline in Jewish students may reflect the lessened interest in a medical career among American young people in general during the past decade. The reasons for this are argued by medical educators. In varying proportion are the decline of professional autonomy, debasement by malpractice litigation, high cost of education, and increased opportunities for other, often more lucrative, and surely easier occupations.

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